WITHIN CORPORATE LIMITS.

07100

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 65 Offutt St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 65 Offutt St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Catherine Theresa Alkire

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, ~~married, widowed, or divorced~~: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): January 9 1938

8. AGE: Years 2 Months 6 Days 6 If less than one day ... hrs. ... min.

9. Birthplace: Cumberland, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Grayson B Alkire

13. Birthplace: Cumberland, Md.

MOTHER

14. Maiden name: Madeline F Stump

15. Birthplace: Oldtown Md

16. Informant: Madeline Alkire

Address: 65 Offutt St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 18 1940 (month) (day) (year)

Cemetery or crematory: Alkire Cemetery

Location: Alaska - W. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. July 16, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1940, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1940, to July 15 1940 and that I last saw her alive on July 15 1940

Immediate cause of death: Whooping Cough — DURATION: about 3 weeks

Due to: Bronchopneumonia — about 6 days

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. E. Bowers M. D. or other

Address: 33 Vale Date signed: July 16 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

07101

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 312 Waverly Terrace
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: ALLAMONG, BABY BOY (STILLBORN)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20, 1940

8. AGE: Years | Months | Days | If less than one day: STILLBORN hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Charles L. Allamong
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hannah Struckman
15. Birthplace: Maryland

16. Informant: Memorial Hosp.
Address: Cumberland Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof July 20, 1940 (month) (day) (year)
Cemetery or crematory: Destroyed at
Location: Memorial Hosp

18. Funeral director:
Address:

19. July 29 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1940, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1940 to July 20 1940 and that I last saw him ~~alive~~ dead on July 20 1940

Immediate cause of death: Abortion — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wright Reynolds M.D. - M. D. or other

Address: Cumberland Md Date signed: July 26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

07102

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 427 Walnut St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 37 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 427 Walnut St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Bernard Amann

3. (b) Social Security Number: 705-09-9508

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Annie Amann

6(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): July 11, 1881

8. AGE: Years: 59 Months: 0 Days: 8 If less than one day: hrs. min.

9. Birthplace: St. Clair, Dodridge, W. Va. (Town, county, and state)

10. Usual occupation: Machinists Helper

11. Industry or business: B & O. Railroad

FATHER

12. Name: Jacob Amann

13. Birthplace: Germany

MOTHER

14. Maiden name: Mary Droppleman

15. Birthplace: Germany

16. Informant: Paul Amann

Address: 427 Walnut St Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 22, 1940 (month) (day) (year)

Cemetery or crematory: St. Peter's Cemetery

Location: Westernport, Md.

18. Funeral director: D. S. Boal

Address: Barton, Md.

19. July 22 1940 (Date rec'd by registrar) [signature] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19th, 1940, at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1939, to July 19 1940, and that I last saw him alive on July 19 1940.

Immediate cause of death: Chronic myocarditis — DURATION: 1 yr.

Due to:

Due to:

Other conditions: Chronic interstitial nephritis — 4 mo.

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont W. Va. Date signed: 7/20/40

RECEIVED
AUG 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

07103

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 yrs.

Hospital, Institution, or street address where death occurred: 111 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 South St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sarah "Miller" Appel

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Lucas Appel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 20, 1852

8. AGE: Years 87 | Months 8 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Martinsburg, Berkeley Co., W. Va
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: at Home

FATHER
12. Name: John W. Miller
13. Birthplace: Martinsburg W. Va

MOTHER
14. Maiden name: Mary McAllister
15. Birthplace: Martinsburg W. Va.

16. Informant: Harry Appel
Address: 111 South St - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 1940. (month) (day) (year)

Cemetery or crematory: Old Norbourne

Location: Martinsburg W. Va.

18. Funeral director: Jacob Hafer
Address: Cumberland Md.

19. July 20, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1940, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1939, to July 19 1940 and that I last saw her alive on July 18 1940

Immediate cause of death: Arterio Sclerosis

Due to: Cerebral Apoplexy

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION
Over 1935
July 10 1940

Major findings of operations: none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Ur Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. E. Owens M. D. or other

Address: 133 Va Date signed: July 20 1940

M

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(48-B)

07104

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 305 Decatur St

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 305 Decatur St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Miss Carrie Baker.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1875

8. AGE: Years 65 | Months 11 | Days 23 | If less than one day hrs. min.

9. Birthplace Rockwood Pa. (Town, county and state)

10. Usual occupation Seamstress

11. Industry or business Invalid at home

FATHER 12. Name W H Baker

13. Birthplace Pa

MOTHER 14. Maiden name Lusrettia Brubaker

15. Birthplace Penna

16. Informant Mrs J W Reitz

Address Cumberland Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof July 17 40 (month) (day) (year)

Cemetery or crematory Centerville Cemetery.

Location Centerville Pa.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. July 16 1940 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

Zimmerman

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1940 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1939, to July 15, 1940

and that I last saw her alive on July 14, 1940

Immediate cause of death	DURATION
Carcinoma of uterus	11 months
Carcinomatosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M.D.
M. D. or other

Address 105 Centre St. Cumberland, Md. Date signed 7/16/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-a

CERTIFICATE OF DEATH

07105

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? one week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Taylor
City or town: Grafton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK BENNETT

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie Davis
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): June 1, 1873

8. AGE: Years	Months	Days	If less than one day
67	1	7	....hrs. ....min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: William Bennett
13. Birthplace: England

MOTHER
14. Maiden name: Mary Jacobs
15. Birthplace: West Virginia

16. Informant: Mrs. Frank Bennett
Address: Rt. 1 Grafton W. Va.

17. Burial, cremation, or removal. Which? Removal. Date thereof: July 8 40 (month) (day) (year)
Cemetery or crematory: Grafton Cem
Location: Grafton W. Va.

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. July 8, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1940 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1- 1940, to 7-8- 1940 and that I last saw h.i.m alive on 7-8- 1940

Immediate cause of death: Myocardial degeneration
Arteriosclerosis
Benign hypertrophy prostate

DURATION

Due to:

Due to:

Other conditions: Chr. Prostatitis

(Include pregnancy within 3 months of death)

Major findings of operations: Prostatic resection Date of op. 7-8-40

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard L. Folson, M.D.
M. D. or other
Address: Cumberland, Md. Date signed: 7-8-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(170-C)

07106

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: 519 Virginia Ave. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Cumberland
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MRS. BERNICE WEESE BOCK

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Albert Bock

6(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Jan 13 1915

8. AGE: Years 25 Months 6 Days 9 If less than one day ___ hrs. ___ min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Housework for Mr. & Mrs.

11. Industry or business: Melvin, 519 Va. Ave., City

FATHER
12. Name: Arthur L. Weese
13. Birthplace: West Virginie

MOTHER
14. Maiden name: Gladys Woods
15. Birthplace: West Virginia

16. Informant: Arthur L Weese

Address: 28 Green St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25 1940 (month) (day) (year)

Cemetery or crematory: St Peters & Paul

Location: Fayette St Cumberland Md

18. Funeral director: Fanis Stein Inc

Address:

19. July 24 1940 (Date rec'd by registrar) J.P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22, 1940 @ 10:12 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1940, to July 22 1940 and that I last saw her alive on July 22 1940

Immediate cause of death: Fractured Skull

Due to: Intracranial hemorrhage: Automobile accident.

Due to: Struck, on highway, by automobile. C.W.G.R. July 21st, 1940, at Wiley's Ford, W. Va.

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: None

DURATION: July 22

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~: accident Date of July 22, 40

Where did injury occur? Highway - W. Va. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) on highway.

Means of injury: Injured at work? No

23. SIGNATURE: W.P. Hodges M.D. M. D. or other

Address: Cumberland, Md Date signed: 7/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-D)

CERTIFICATE OF DEATH

07107

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
Mt Savage
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.: mt - Savage -
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ida May Brant

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Widow

6.(b) Name of husband or wife: Ernest Brant dead
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 21, 1866

8. AGE:

Years	Months	Days	If less than one day
74	5	4	..... hrs. ..... min.

9. Birthplace: Cumberland md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Samuel L. Piper
13. Birthplace: md.

MOTHER
14. Maiden name: Caroline Dilla
15. Birthplace: md.

16. Informant: Lloyd Brant
Address: Mt - Savage -

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 27, 1940 (month) (day) (year)
Cemetery or crematory: M. E. - Cemetery mt - Savage
Location: mt. Savage - md.
18. Funeral director: Louis Stein Inc -
Address: Cumberland, md.

19. July 27 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1940 at 4 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to July 25 1940 and that I last saw h..... alive on July 20 1940

	DURATION
Immediate cause of death: Acute Dilatation of heart -	2 hours
Due to: Chronic Myocarditis and Endocarditis	several months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. Allen E. Wennemund M. D. or other
Address: 4 Emerson Cumberland Date signed: July 25 - 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94b)

WITHIN CORPORATE ...

McLane

071089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or Institution: 55 Broadway

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 55 Broadway (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Anthony Delonadh Caton

3. (b) Social Security Number: 212-10-9271

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Caton

6(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): January 24, 1890

8. AGE: Years 50 | Months 5 | Days 8 | If less than one day ___ hrs. ___ min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Fireclay mines

FATHER

12. Name: Peter Caton

13. Birthplace: Maryland

MOTHER

14. Maiden name: Clara McKenzie

15. Birthplace: Maryland

16. Informant: Mrs. Louise Caton,

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 6, 1940 (month) (day) (year)

Cemetery or crematory: Finzel cemetery

Location: Finzel, Md.

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. July 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1940, at 7:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1940, to July 2 1940, and that I last saw him alive on June 26 1940.

Immediate cause of death: Angina Pectoris — DURATION: 2 wk.

~~Due to~~ suspected miliary tuberculosis — 10 wks

Due to: This death should be assigned to angina pectoris and not to miliary

Other conditions: Tuberculosis. C.W.E.R.

(Include pregnancy within 3 months of death)

Major findings at autopsy: Dr. Spencer.

~~Of operations~~ Extensive pulmonary silicosis, pulmonary emphysema, right ventricular hypertrophy and dilatation.

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. O. McLane Jr. MD (M. D. or other)

Address: Frostburg Md — Date signed: July 5 1940

RECEIVED
AUG 2 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07109

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (49-a)

County Allegany — Registration Dist. No. 4

Village or City Cumberland — No. Allegany Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Jeanette C. Close — If U. S. Veteran, specify WAR ...

(a) Residence: No. La Vale R.F.D. #1 Ward. ...

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Eugene Close

6. DATE OF BIRTH (month, day, and year): Feb. 23-1899

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: —

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country): Newark N.J.

FATHER

13. NAME: Mathew Rogers

14. BIRTHPLACE (city or town) (State or country): Newark N.J.

MOTHER

15. MAIDEN NAME: Katherine Taylor

16. BIRTHPLACE (city or town) (State or country): Newark N.J.

17. INFORMANT: Eugene Close (Address) La Vale, Md

18. BURIAL, CREMATION, REMOVAL: St. Peters R.C. Church Place Cumberland Date July 25, 1940

19. UNDERTAKER: J. J. Dunn (Address) Frostburg Md

20. FILED July 29, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: July (Month) 29 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 7 1940 to July 29 1940

I last saw h[illegible] alive on July 28 1940, death is said to have occurred on the date stated above, at 6 A.M. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinomatosis	

Other Contributory Causes of Importance: Papilloma Carcinoma of Ovary

Neme of operetion ... Date of ...

What test confirmed diegnosis? ... Wes there en eutopsy? ...

23. If death was due to externel ceuses (VIDLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury ...

Neture of injury ...

24. Was diseese or injury in any way related to occupetion of deceesed? ...

If so, specify ...

(Signed) A. P. Eugene ... M. D.

(Address) Cumberland Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED
AUG 6 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-C)

07110

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Deer Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME: Mrs. Ada Ohler Cooper

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: William Thomas Cooper

6(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): July 19, 1897

8. AGE:

Years	Months	Days	If less than one day
43	0	5	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Ohler
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Susan Grim
15. Birthplace: Pennsylvania

16. Informant: Memorial Hosp.
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28/40 (month) (day) (year)
Cemetery or crematory: Mt Talber Cemetery
Location: Normansville Pa

18. Funeral director: O. F. Sharpless
Address: Blaine, WVa

19. July 26 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1940 @ 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1940 to July 24 1940, and that I last saw her alive on July 24 1940.

Immediate cause of death: Carcinoma Uterus — DURATION: 2 years.

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland, Md Date signed: July 28 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-0)

07111

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: West Main St.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 11 mos 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: West Main St (If rural give LOCATION)

2(c) IF YETERAN, NAME WAR: —

3. (a) FULL NAME: Donald Crowe

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife: —

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): August 2, 1939

8. AGE: Years: — Months: 11 Days: 24 If less than one day: hrs. min.

9. Birthplace: Lonaconing Allegany Co., Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Francis Crowe

15. Birthplace: Lonaconing, Md.

16. Informant: Belle Crowe

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28, 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. July 27 1940 (Date rec'd by registrar) E. Doy Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 , to — 19 , and that I last saw h alive on — 19 .

Immediate cause of death: Cholera Infantum

From history, did not see child before death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hersey M. Hodgson M.D. M. D. or other

Address Date signed

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

07112

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

101 Park St -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jennie B. Deffenbaugh.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Daniel S. Deffenbaugh

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21, 1867

8. AGE: Years	Months	Days	If less than one day
73	4	5	..... hrs. ..... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name William D. Hanks

13. Birthplace Pa.

MOTHER 14. Maiden name Isabelle Chamberlain

15. Birthplace Pa.

16. Informant Carleton W. Hanks

Address 213 Maryland Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1940 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md.

18. Funeral director Louis Stein Son

Address Cumberland, Md.

19. July 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26-40 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-10-1936 19 ..... to 7-26-40 19 .....

and that I last saw h... alive on 7-24-40 19 .....

Immediate cause of death	DURATION
Generalized Arteriosclerosis	4 yrs.
Due to Diabetes	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. C. Zimmerman M. D. or other

Address ..... Date signed 7-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-P)

CERTIFICATE OF DEATH

07113

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: ALLEGANY COUNTY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: La. Vale - Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: BABY BOY DUKE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): JULY 25, 1940

8. AGE: Years	Months	Days	If less than one day
		2	..... hrs. ..... min.

9. Birthplace: CUMBERLAND, MARYLAND (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: EDGAR T. DUKE
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: YVETTE STERNE
15. Birthplace: OHIO

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jul. 29 1940 (month) (day) (year)
Cemetery or crematory: Hillcrest Bur. Park
Location: Cumberland Md

18. Funeral director: Louis Stein Inc.
Address: Cumberland Md

19. July 29 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JULY 27, 1940, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 25, 1940, to JULY 27, 1940 and that I last saw him alive on JULY 27, 1940

Immediate cause of death	DURATION
Congenital Hemophelia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Dwight Reynolds M.D.
M. D. or other
Address: Cumberland Md. Date signed: July 27 1940

RECEIVED
AUG 8 1940
BUREAU V. S.

07114

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: The Reeves Clinic

How long in hospital or institution? 6 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Garrett

City or town: Hutton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Paul Otto Filsinger

3. (b) Social Security Number: 216-07-4034

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband or~~ wife: Alta Virginia Harvey

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): Aug. 21st, 1907

8. AGE: Years: 32 Months: 10 Days: 23 If less than one day: 2 hrs. 20 min.

9. Birthplace: Deer Park, Garrett, Maryland (Town, county, and state)

10. Usual occupation: Pipe fitter

11. Industry or business: unemployed

FATHER

12. Name: Otto Filsinger

13. Birthplace: Germany

MOTHER

14. Maiden name: Catherine Pearl Castell

15. Birthplace: near Hoyes, Garrett County, Md

16. Informant: Mother—Mrs. C. Durst

Address: Swanton, Garrett County, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16 1940 (month) (day) (year)

Cemetery or crematory: Broadway Cemetary

Location: Swanton R D 2, Md.

18. Funeral director: Wm Winterberg

Address: Grantsville Md

19. July 15 1940 (Date rec'd by registrar) A. Frymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14th 1940, at 220 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1940, to July 14 1940 and that I last saw him alive on July 14 1940

Immediate cause of death: Traumatic Shock

Due to: Gun Shot wound of abdomen

Due to: Genitalia left thigh

Other conditions: Alcoholic intoxication

(Include pregnancy within 3 months of death)

DURATION: 7/13/40

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: 7/13/40

Where did injury occur? Grantsville Md (City or town) Garrett (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Gun Shot Injured at work?

23. SIGNATURE: W. Reeves M.D. (M. D. or other)

Address: Westernport Md Date signed: 7/16/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
U. V. S.

07115

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 219 Maple St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 219 Maple (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Henry L. Finzel

3. (b) Social Security Number: 215-10-4433

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lilly Machin

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 7 - 1875

8. AGE: Years: 65 Months: 1 Days: 14 If less than one day: hrs. min.

9. Birthplace: Finzel - Garrett - Md. (Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business

FATHER
12. Name: Henry Finzel
13. Birthplace: Germany

MOTHER
14. Maiden name: Sarah McKenzie
15. Birthplace: Pa.

16. Informant: Clarence Finzel

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23-1940 (month) (day) (year)

Cemetery or crematory: Finzel

Location: Finzel, Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md

19. July 22nd 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939, to July 21 1940, and that I last saw him alive on July 19 1940.

Immediate cause of death: Exhaustion

Due to: Transverse Myelitis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION: several months; 1 year

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. Alan G. Murray Md M. D. or other

Address: 41 Green St Cumberland Md Date signed: July 22 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T)

RECEIVED
AUG 3 1940
U. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

07116

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town near Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R F D #2 Rt 40 East

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D #2 Rt 40 East
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jarred B. Free.

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Divorced

6.(b) Name of husband or wife: Sarah Summers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 10 1864

8. AGE: Years 75 | Months 9 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace: New Town Va.
(Town, county, and state)

10. Usual occupation: General Laborer.

11. Industry or business: Farm.

FATHER
12. Name: Isaac Free
13. Birthplace: Stuartstown Pa

MOTHER
14. Maiden name: Melvina Lentz
15. Birthplace: York Pa

16. Informant: Mrs Chas Forster

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 40 (month) (day) (year)

Cemetery or crematory: Greenmount Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. July 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1940, at 11 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1940, to July 6 1940 and that I last saw him alive on July 6 1940

Immediate cause of death: Auricular Fibrillation — DURATION: weeks

Due to: Hypertensive Cardiac Vascular Renal Disease — years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. Schindler Ens M. D. or other

Address: 41 Greene St. Date signed July 8 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136)

CERTIFICATE OF DEATH

07117

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Oldtown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Furlow, Anna

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John Furlow

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE:

Years	Months	Days	If less than one day
68			hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Odd Jobs

FATHER 12. Name George Keefer

13. Birthplace Unknown

MOTHER 14. Maiden name Mary Rosecamp

15. Birthplace Not Known

16. Informant Harley Robertson

Address Oldtown Md

17. Cemetery, Orchard (Burial, cremation, or removal. Which?) Date thereof 7-27-40 (month) (day) (year)

Cemetery or crematory Cemetery Orchard

Location Maryland View

18. Funeral director Kelly Hunsaker Funeral Home

Address Pen Mar Road R.F.D. #1 Cumberland Md

19. July 26, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 Th 1940, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-23 1940, to 7-25 1940, and that I last saw h alive on 7-24 1940.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	?
Due to	
Due to	
Other conditions Chronic Nephritis Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D. M. D. or other

Address Cumberland Md Date signed 7-25-40

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

07118

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
515 Green St -

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Green St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME David Gates

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of ~~husband or~~ wife Golden Bates

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1869?

8. AGE: Years 71 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Caretaker

11. Industry or business McDonald estate

FATHER
12. Name David Gates
13. Birthplace Md.

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Golden Gates

Address 515 Green St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 - 1940 (month) (day) (year)

Cemetery or crematory Cemetery - Rose Hill

Location Cumberland Md

18. Funeral director Lewis Stein Inc

Address Cumberland

19. July 15 1940 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1940 at 1:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22, 1940, to July 13, 1940 and that I last saw him alive on July 12, 1940

	DURATION
Immediate cause of death Edema of the Lungs	1 Day.
Due to Carcinoma of the rectum	about one year.
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE George C. Hollomand M.D.
M. D. or other

Address 145 Hanover St. Date signed July 13, 1940

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

07119

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 526 Reihl Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Lawrence Gerderman.

3.(b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6 1923

8. AGE: Years 17 Months — Days 18 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Anthony R. Gerderman
13. Birthplace Cumberland Md.

MOTHER
14. Maiden name Eleanor Harman
15. Birthplace Barton Md.

16. Informant Anthony R. Gerderman

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 '40 (month) (day) (year)

Cemetery or crematory St. Peter & Paul's Cem.

Location Cumberland Md

18. Funeral director Louis Stein Inc.

Address Cumberland

19. July 25 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1940 at 12 45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1940 to July 24 1940 and that I last saw him alive on July 23 1940

Immediate cause of death: Fracture 5th Arrival Vertebra pneumogastric — DURATION 2 days

Due to: Diving in creek

Due to: striking head on bottom of creek

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 21 40

Where did injury occur? Fort Ashby Mineral W Va (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Eastern Creek

Means of injury Diving in creek Injured at work? no

23. SIGNATURE F. Alan G. Murray M.D. M. D. or other

Address 41 Green St Cumberland Md Date signed July 24 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

07120

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(M)

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town ~~Cumberland~~ Cresaptown Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Clinton Paul Grant

3. (b) Social Security Number 220-10-7676

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Single

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1919

8. AGE: Years 20 Months 10 Days 16 If less than one day hrs. min.

9. Birthplace Beryl W. Va.

(Town, county, and state)

10. Usual occupation Parcel Post Boy

11. Industry or business Silk Mill

FATHER

12. Name Chas. R. Grant

13. Birthplace Cresaptown Md

MOTHER

14. Maiden name Eva Burke

15. Birthplace Orleans Md.

16. Informant Chas R. Grant

Address Cresaptown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7, 1940 (month) (day) (year)

Cemetery or crematory Eckhart

Location Eckhart Maryland

18. Funeral director Jacob Hafer

Address Cumberland Md

19. July 5, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 11.40

20. DATE OF DEATH July 4th., 1940, at A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,

and that I last saw h alive on 19 ,

Immediate cause of death Fractured third cervical vertebra, ruptured left kidney.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of July 4th., '40

Where did injury occur? Near Cresaptown, Allegany, Maryland. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury auto accident. Injured at work? no

23. SIGNATURE Linnie H. Conon, M.D. M. D. or other

Address Cumberland, Maryland Date signed 7/5/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (170-C)

Reg. Dist. No. 8

07121

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Pikeport (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 60 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Lonaconing, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Douglas Avenue (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME William A. Green

3 (b) If veteran, name war No

3 (c) Social Security No. 244-10-7300 (Ross) ~~None~~

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1880

8. AGE: Years 60 Months 4 Days — If less than one day ____ hr. ____ min.

9. Birthplace Lonaconing (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal Mine

FATHER
12. Name William S. Green
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Coleman
15. Birthplace Barton Maryland

16 (a) Informant Ruth Barnard
(b) Address Lonaconing

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1940 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Md.

18 (a) Funeral director M. Eichhorn
(b) Address Lonaconing, Md.

19 (a) July 13 1940 (Date rec'd by registrar) (b) E. Don Taylor Registrar

MEDICAL CERTIFICATION

20. Date of death July 10th., 1940, at 8.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw him alive on ____ 19__.

Immediate cause of death	Duration
Fractured skull.	
Due to	
Due to	
Other conditions Fractured pelvis--crushed chest. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 10th., 1940
(c) Where did injury occur? Near Pekin, Allegany, Maryland. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Highway # 36 While at work? no (Specify type of place)
(e) Means of injury struck by automobile while walking on highway.

23. Signature Pierce H. Corson M.D. M. D. or other
Address Cumberland, Md. Date signed 7/11/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (73-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 071229

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 172 Orward
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Arch Griffith
3. (b) Social Security Number: 214-01-6645

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Maud Skidmore
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Feb. 26 - 1897
8. AGE: Years 43 | Months 5 | Days 12 | If less than one day ____ hrs. ____ min.
9. Birthplace: Frostburg - Alleg. Md. (Town, county, and state)
10. Usual occupation: coal miner
11. Industry or business: Mining coal
FATHER
12. Name: Wm Griffith
13. Birthplace: Frostburg Md.
MOTHER
14. Maiden name: Kathern Hartig
15. Birthplace: Frostburg Md.
16. Informant: Mrs Hugh Duncan
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10 - 1940 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg, Md.
18. Funeral director: J J Durst
Address: Frostburg, Md
19. 7 - 10 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1940, at 6:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940, to July 8 1940, and that I last saw him alive on July 8 1940.
Immediate cause of death: Pernicious anemia — DURATION: 6 wks.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Dt operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: H. C. Diehl M. D. or other
Address: Frostburg, Md Date signed: 7/9/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

Outside of City Limits

STATE OF MARYLAND—CERTIFICATE OF DEATH

07123

1. PLACE OF DEATH (92d)

County Allegany Registration Dist. No. 4

Village or City Near Cumberland No. Wm's. Rd. Route #2 St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Perry Franklin Gross If U. S. Veteran, specify WAR

(a) Residence: No. Williams Rd., Route #2 Ward. Social Security No. 705-09-6697

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Robertson

6. DATE OF BIRTH (month, day, and year) April 9, 1880

7. AGE Years 60 Months 3 Days 13 If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Car Repairman

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. B. and O. R.R. Co.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Allegany Co., Md.

FATHER

13. NAME William Gross

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Elizabeth Robertson

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT (Address) LeRoy DeVore 229 Oak St., City

18. BURIAL, CREMATION, OR REMOVAL Camp Hill, Pau Pau Wilta Date July 30, 1940

19. UNDERTAKER (Address) V. L. Lempereur Cumberland, Md.

20. FILED July 30, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 27 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 21, 1940, to July 27, 1940

I last saw him alive on July 27, 1940; death is said to have occurred on the date stated above, at 10:00 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral arteriosclerosis	?

Other Contributary Causes of importance:

Endocarditis, Chronic.	5/21/40
Duration: Unknown. C.W.G.R.	

Name of operation ____ Date of ____

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19__

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ____

(Signed) L. J. Lanich M. D.

(Address) Cumberland Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

07124

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Rural - Near Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs.

Hospital, institution, or street address where death occurred: Borden - Near Frostburg

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Borden (If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Near Frostburg Md (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Minnie "Brode" Hager

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Charles Hager

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feb 22, 1863

8. AGE: Years 77 | Months 4 | Days 22 | If less than one day ... hrs. ... min.

9. Birthplace: Shaft Allegany Co, Md. (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business: At Home

FATHER 12. Name: Henry Brode

13. Birthplace: Germany

MOTHER 14. Maiden name: Henry Wagner

15. Birthplace: Germany.

16. Informant: Frank Hager

Address: Borden Mines, Md

17. ~~Alle~~ Burial (Burial, cremation, or removal. Which?) Date thereof: July 17, 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. 7-17 1940 mrs. A. R. Walker (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1940, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1940, to July 15 1940 and that I last saw her alive on July 13 1940

Immediate cause of death	DURATION
Chronic Myocarditis	1 yr
Due to Hypertension	??
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. M. D. or other

Address: Frostburg Md Date signed 7-17-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58d)

CERTIFICATE OF DEATH

07125

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 6 3/4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Miss Dortha Hardesty

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1921

8. AGE: Years: 18 | Months: 10 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Ira Hardesty
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Lulu Roy
15. Birthplace: Maryland

16. Informant: Ira Hardesty
Address: Mt. Lake Park, Md.

17. (Burial, cremation, or removal. Which?) Removal Date thereof: July 11, 1940 (Month) (day) (year)

Cemetery or crematory: Oakland Cem.

Location: Oakland, Md.

18. Funeral director: Herbert C. Leighton

Address: Oakland, Md.

19. July 10 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1940, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8, 1940 to July 9 1940 and that I last saw her alive on July 8 1940

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Rheumatic Heart Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other
Address: Cumberland Date signed: 7-9-40

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AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07126

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 408 Walnut St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 408 Walnut St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Harry Higgins

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9 1869

8. AGE: Years 71 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Henry Higgins
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth Hudson
15. Birthplace: Md.

16. Informant: Mrs Nellie Mack
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 11 '40 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. July 10 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1940, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1940, to July 8 1940 and that I last saw him alive on July 8 1940

Immediate cause of death: Cerebral Hemorrhage — DURATION: 12 hr

Due to: Hyper tension — unknown

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L. J. Lanich M.D. M. D. or other

Address: Cumberland Md Date signed: 7-9-40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 8 1940
BUREAU U. S.

WITHIN CORPORATE LIMITS.

07127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(50)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland 333 Fayette St.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sylvan Retreat

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lillie May Horn.

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed.

6.(b) Name of husband ~~or wife~~ Ross Horn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22, 1870.

8. AGE: Years 70 | Months 2 | Days 2 | If less than one day ..... hrs. ..... min.

9. Birthplace Schellsburg, Bedford Pa.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name S. Tucker

13. Birthplace Penna.

MOTHER

14. Maiden name Long Tucker.

15. Birthplace Penna.

16. Informant JOHN HORN

Address 457 Columbia St. CUMBERLAND, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 / 28 / 40 (month) (day) (year)

Cemetery or ~~crematory~~ Schellsburg Cem

Location Schellsburg Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman, Penna.

19. July 27 1940 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1940 at 10 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 1 1940, to July 26 1940 and that I last saw her alive on July 24 1940

Immediate cause of death Carcinomatosis of chest

Due to Carcinoma of breast.

~~Due to~~ Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION: 1 yr.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. ~~or other~~

Address Cumberland Date signed 7-27-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07128 9

Reg. Dist. No.

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Welsh Hill
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Walnut Level
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Elizabeth Hunter

3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Alfred Hunter
6(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): Feb 23 - 1889
8. AGE: Years 51 Months 4 Days 12 If less than one day hrs. min.
9. Birthplace: New Mexico (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: Home
FATHER 12. Name: Hugh Kelso
13. Birthplace: Scotland
MOTHER 14. Maiden name: Mary Elizabeth Boyd
15. Birthplace: England
16. Informant: Elizabeth Hunter
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7-1940 (month) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg
18. Funeral director: J. J. Durst
Address: Frostburg, Md.
19. July 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1940, at 1:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940 to July 5 1940, and that I last saw her alive on July 4, 1940.

Immediate cause of death	DURATION
Acute edema of lungs	2 days
Due to Chronic myocarditis	3 yrs.
Due to	
Other conditions Large inoperable uterine fibroid (Include pregnancy within 3 months of death)	5 yrs.

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. E. Gattens, M.D. M. D. or other
Address: Frostburg, Md. Date signed: 7/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07129

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred: Buckingham Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Buckingham Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Claiborne Morrison James

3.(b) Social Security Number 214-05-4026

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Nancy Johnson

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 6 1872

8. AGE: Years 68 Months 1 Days 24 If less than one day ..... hrs. ..... min.

8. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Construction Co.

FATHER
12. Name Jay James
13. Birthplace Va.

MOTHER
14. Maiden name Nancy Boling Morrison
15. Birthplace Va.

16. Informant Mrs John B Mordock

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. Aug 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1940 at 5 39 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1939, to July 30 1940 and that I last saw h— alive on July 29 1940

Immediate cause of death: Pulmonary Embolism

Due to Popliteal Thrombosis

Due to Prostatic Resection + Pelvic Extraction

Other conditions Benign prostatic enlargement. C.W.G.R.

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. C. Barnes M.D. M. D. or other

Address Cumberland Md Date signed 7-31-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47C)

07130

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, La Vale, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: La Vale, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: La Vale, Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Burgess Tardy Jenkins

3.(b) Social Security Number: 214-05-6658

4. Sex: Male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of ~~husband~~ or wife: Anna Wolf

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 3, 1881

8. AGE: Years: 59 Months: 1 Days: 24 If less than one day ... hrs. ... min.

9. Birthplace: Hancock, Md. (Town, county, and state)

10. Usual occupation: Auditor

11. Industry or business: News Paper

FATHER 12. Name: Solomon Jenkins

13. Birthplace: Md.

MOTHER 14. Maiden name: Helen Beard

15. Birthplace: Md.

16. Informant: Mrs J. B. Jenkins

Address: La Vale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30. 40 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. July 30, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 1st 1940, to July - 27 1940 and that I last saw her alive on July - 27 1940

Immediate cause of death: Carcinoma of Left Sup. Lobe of Left Lung - 8 Mos.

Due to: (Bronchogenic Carcinoma)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: H. W. Chason M.D. M. D. or other

Address: 126 Mount Cumberland Md. Date signed: July 29 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

07131

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany Co.

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred: 708 Gephart Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New York County: ✓

City or town: Haverstraw
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Rachael Dunlap Jobson

3.(b) Social Security Number: none

4. Sex: ~~F~~

5. Color or race: W

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: Geo. Robert Jobson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 29 1858

8. AGE: Years: 82 Months: 3 Days: 20 If less than one day ..... hrs. ..... min.

9. Birthplace: County Antrim, Ireland
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: At home

FATHER
12. Name: Wm Allison
13. Birthplace: Ireland

MOTHER
14. Maiden name: ~~Not Known~~ Mary Couples
15. Birthplace: ~~Not Known~~ Ireland

16. Informant: Grace Cramer

Address: Cumberland, Md

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: July 22 1940
(month) (day) (year)

Cemetery or crematory: Mt. Repose

Location: Haverstraw N.Y.

18. Funeral director: Jacob Hofer

Address: 230 Baltimore Ave. Cumberland Md

19. July 19 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1940, at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940, to July 19 1940 and that I last saw h ~~alive~~ dead on July 19 1940.

Immediate cause of death: Coronary Thrombosis — DURATION: 4 hours

Due to: Cardio-Vascular Renal Disease

Due to: Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. M. Schindle M. D. or other

Address: 41 Greene St. Date signed: July 19, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 26 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

07132

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 532 N - Mechanic St -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James R. Johnston Sr.

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of ~~husband or~~ wife: Anna Shartzers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30 1862

8. AGE: Years 77 | Months 12 11 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Penna
(Town, county, and state)

10. Usual occupation Retired Engineer - Penna R+R

11. Industry or business Penn. R.R.

FATHER
12. Name James Johnston
13. Birthplace Pa.

MOTHER
14. Maiden name Harrich Schaffer
15. Birthplace Pa.

16. Informant Joseph St. [illegible]
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.
Address Cumberland, Md

19. July 31, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29/40 19..., at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/20/40 19..., to 7/29 1940 and that I last saw him alive on 7/29/40 19...

Immediate cause of death: Cerebral failure due to heart

Due to

Due to

Other conditions Hernioplasty Hernia of testis - inguinal

(Include pregnancy within 3 months of death)

Major findings of operations Large inguinal hernia

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Rozum MD M. D. or other

Address Cumberland Md Date signed 7/29/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

07133

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred: 308 Front St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Front St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Emma Virginia Kalbaugh

3. (b) Social Security Number: ✓

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): March 4 1865

8. AGE: Years 75 Months 4 Days 26 If less than one day ... hrs. ... min.

8. Birthplace: Westernport Alleg. Md. (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own home

FATHER
12. Name: John D. Kalbaugh
13. Birthplace: Westernport, Md.

MOTHER
14. Maiden name: Mary Simmons
15. Birthplace: Hartmansville, W. Va.

16. Informant: Charles F. Kalbaugh

Address: Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 2, 1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport Md.

18. Funeral director: D. S. Boal

Address: Barton Md.

19. Aug. 1 1940 (Date rec'd by registrar) A. [illegible] M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th 1940 at 3:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1940, to July 30 1940 and that I last saw her alive on July 30 1940

Immediate cause of death: Broncho-Pneumonia — DURATION: 3 days

Due to

Due to: Fractured Rib; due to — July 1-1940

Other conditions: accidental fall; in her home, June 15th, 1940. C.W.S.P. (Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Not accident. Date of June 15, 1940.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): in her home.

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: R. E. Berry M.D. M. D. or other

Address: Piedmont W. Va. Date signed: 8/1/40

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

07134

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Frostburg R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Frostburg-R.F.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Mrs Maude C. Kear

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of ~~husband~~ or wife Late Isaac Kear
6(c) If alive, give age — 70 1876 Years

7. Birth date of deceased (mo., day, yr.) Feb 12 -

8. AGE:

Years	Months	Days	If less than one day
76	4	21	— hrs. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation At Home
11. Industry or business Housewife

FATHER
12. Name John Hagen
13. Birthplace Germany

MOTHER
14. Maiden name Christina Klupenstein
15. Birthplace Germany

16. Informant George C. Kear
Address Frostburg, Md. R.F.D.

17. — Burial — Date thereof July 8-40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Allegany County Cemetery
Location Frostburg, Md.

18. Funeral director U. L. Lamberson
Address Cumberland, Md.

19. 7-8 1940 Mrs. A. B. Hacker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10, 1940, to May 20 1940, and that I last saw h-- alive on May 20, 1940

Immediate cause of death	DURATION
Chronic myocarditis	1938
Due to Uraemia	5/1940
Due to Diabetes	1936
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Clay R. Durrett, M. D. or other
Address Cumberland Date signed July 6, 1940

RECEIVED
AUG 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07135

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution Allegany Hosp.
Stay in hospital or inst. (yrs., or mos., or days) 4 wks
Stay in this community (yrs., or mos., or days) 4 yrs, 5 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Gilmore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR Spanish American

3. (a) FULL NAME John P. Kennedy

3. (b) Social Security Number 215-18-8931

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary L. Nolan
6(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) January 19, 1883

8. AGE:

Years	Months	Days	If less than one day
57	6	2	hrs. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual occupation Horseman
11. Industry or business Race Tracks
FATHER 12. Name James Kennedy
13. Birthplace Ireland
MOTHER 14. Maiden name Mary DeBurt
15. Birthplace Unknown
16. Informant Mrs. Mary Kennedy
Address Gilmore, Maryland
17. Burial Date thereof July 24, 1940
(Burial, cremation, or removal: Which?) (month) (day) (year)
Cemetery or crematory Laurel Hill Cem.
Location Mascon Md.
18. Funeral director M. Eichhorn
Address Lonaconing, Md.
19. July 23 1940 J. B. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1940, at 8:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23 1940, to July 21 1940, and that I last saw h alive on 19
Immediate cause of death Chronic Myocarditis — DURATION 2 yrs.
Due to
Due to
Other conditions Syphilis — 20 yrs.
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. A. Jaraskis M. D., or other
Address Cumberland, Md Date signed 7/23/40

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

07136

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Vindex

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME CLYDE KNOX

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Judy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 19, 1868

8. AGE: Years	Months	Days	If less than one day
71	11	11	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired--Old Age Pension

11. Industry or business

FATHER

12. Name: Henry Knox

13. Birthplace: Maryland

MOTHER

14. Maiden name: Elizabeth Green

15. Birthplace: Maryland

16. Informant: Memorial Hospital

Address: Cumberland Md

17. (Burial, cremation, or removal. Which?) Removal Date thereof aug 2/40 (month) (day) (year)

Cemetery or crematory: North Glade

Location: Swanton Md

18. Funeral director: O. F. Shaples

Address: Blaine, W Va

19. (Date rec'd by registrar) July 31 1940 J. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30, 1940, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1940, to July 30 1940 and that I last saw h[illegible] alive on July 30 1940

Immediate cause of death: Chronic Myocarditis

DURATION: 5 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Cumberland Md. Date signed: 7/30/40

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Race St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Infant Leslie

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7 1940

8. AGE: Years Months Days If less than one day ..... hrs. ..... min.

Stillborn

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation none.

11. Industry or business

FATHER
12. Name Howard Leslie
13. Birthplace Pa.

MOTHER
14. Maiden name Ann Maffley
15. Birthplace Cumberland Md

16. Informant Howard Leslie

Address 103 Race St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-11-40 (month) (day) (year)

Cemetery or crematory Sts Peter & Pauls Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc

Address Cumberland

19. July 11, 1940 J. P. Franklin, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1940, at 10 30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1940, to July 7 1940 and that I last saw h..... alive on ..... 19.....

Immediate cause of death Macerated Fetus

Due to —

Due to —

Other conditions ?

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations —

Date of op. —

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE W. Royce Hodges, M.D. M. D. or other

Address Cumberland, Md. Date signed July 8, 40

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07138

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months.

Hospital, Institution, or street address where death occurred:

216 Oak St.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany. (Garrett)

City or town: Vindex, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Martha Willison Lewis

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Abraham Lewis

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 25, 1877

8. AGE: Years	Months	Days	If less than one day
63	3	29	hrs. min.

9. Birthplace: Eckhart, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: House work

11. Industry or business: at Home

FATHER — 12. Name: John Willison

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Agnes Walkenshaw

MOTHER — 15. Birthplace: Scotland.

16. Informant: Abraham Lewis

Address: 216 Oak St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 1940 (month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart, Md.

18. Funeral director: Jacob Hafer.

Address: Cumberland Md.

19. July 26 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/24/41 19..., at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/18/40 19... to 7/24/40 19...

and that I last saw h... alive on 7/24/40 19...

Immediate cause of death	DURATION
Cerebral hemorrhage (second attack)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard J. Williams M.D. M. D. or other

Address: 34 Va. Ave. Date signed 7/25/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 8 1940
BUREAU Y. S.

WITHIN CORPORATE LIMITS

07139

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 424 Arch St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 Arch St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George W Linn

3. (b) Social Security Number 705-07-6554

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name ~~of husband~~ or wife: Cora Smith

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug-29, 1873

8. AGE: Years 67 | Months 10 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business B&O

FATHER
12. Name George Linn
13. Birthplace Scotland

MOTHER
14. Maiden name Mary Gardner
15. Birthplace Scotland

16. Informant Cora Linn

Address 424 Arch St.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof July 27, 1940
(month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland, Md

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. July 27, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1940, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1940, to July 24, 1940 and that I last saw him alive on July 24, 1940

Immediate cause of death: Rocky Mountain Spotted Fever — DURATION 7/12/40

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other

Address Cumberland, Md. Date signed July 25, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07140

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 yr.

Hospital, institution, or street address where death occurred: 69 Greene St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 69 Greene St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George L. Long

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes C Leppold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 1866

8. AGE: Years: 73 Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Tobacco Broker

11. Industry or business

FATHER 12. Name: George Long

13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth Fletcher

15. Birthplace: Germany

16. Informant: Agnes C Long

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 8 '40 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. July 6, 1940 (Date rec'd by registrar) J L Franklin MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1940 at 8 40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/40 19.. to 7/4/40 19.. and that I last saw him alive on 7/4/40 19..

Immediate cause of death	DURATION
Acute cholecystitis, with	
Immediate cause of collapse	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J L K Rozum M D

M. D. or other

Address: Cumberland Md Date signed: 7/5/40

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

07141

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 month
Stay in this community (yrs., or mos., or days): 68 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 310 Baca St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Missouri Long
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Adolph Long
6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1871

8. AGE:

Years	Months	Days	If less than one day
68	9	14	____ hrs. ____ min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: At home

FATHER
12. Name: George Humberson
13. Birthplace: Frostburg Md

MOTHER
14. Maiden name: Marietta Beckman
15. Birthplace: Frostburg, Md.

16. Informant: Virgil Brickey
Address: La Vale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8 1940 (month) (day) (year)
Cemetery or crematory: Sts. Peter & Paul Cem.
Location: Cumberland, Md.

18. Funeral director: Jacob Hafer
Address: Cumberland, Md.

19. July 7, 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 1940 to July 5 1940, and that I last saw her alive on July 5 1940

Immediate cause of death	DURATION
Carcinoma of Cystoma	1938
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. W. Gleason M.D.
M. D. or other
Address: 126 Union St. Cumberland Md. Date signed: 7/9/40

RECEIVED
AUG 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-C)

CERTIFICATE OF DEATH

07142

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Flintstone Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mary F. Mallow

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

B (b) Name of husband or wife: Isaac Mallow

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1866

8. AGE: Years 73 | Months 8 | Days 26 | If less than one day ____ hrs. ____ min.

9. Birthplace: W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jacob F. Dove
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Louisa Harold
15. Birthplace: W. Va.

16. Informant: Gertie Mauzy

Address: Flintstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 27, 1940 (month) (day) (year)

Cemetery or crematory: Odd Fellows Flintstone Cemetery

Location

18. Funeral director: Ephriam Smith

Address: Artemas Penna.

19. July 25 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24, 1940, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1940, to July 24 1940, and that I last saw her alive on July 23 1940.

Immediate cause of death: Shock due to Intestinal resection

Due to: Strangulation of bowels sun July 16 40

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Strangulation of small intestines

Of autopsy

DURATION: 3 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Thos. H. Kaan M. D. or other

Address: Cumberland, Md Date signed: July 25 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Ko-a)

CERTIFICATE OF DEATH

07143

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): 4 Days
Stay in this community (yrs., or mos., or days): Same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 517 Williams St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Mc Dade

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	New Born

6 (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 17, 1940

8. AGE: Years | Months | Days: 4 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Cumberland, Allegany, Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Michael F. Mc Dade
13. Birthplace: Westernport, Md

MOTHER
14. Maiden name: Margaret Laing
15. Birthplace: Cumberland Md

16. Informant: Michael F. Mc Dade
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1940 (month) (day) (year)
Cemetery or crematory: St Patricks Cemetery
Location: Cumberland Md

18. Funeral director: Jacob Hafer
Address: Cumberland Md

19. July 22 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1940 at 405 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1940 July 21 1940
and that I last saw him alive on July 21 1940

Immediate cause of death	DURATION
Intracranial Hemorrhage	
Due to Coma?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A Royce Hodes, Jr. M. D. or other
Address: Cumberland Md Date signed 7/21/40

RECEIVED
AUG 6 1940
BUREAU V. R.

07144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegeny

City or town R.F.D.I. - Frostburg -

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) Hoffman, Rural

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md - County Allegeny

City or town Hoffman Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. #1 - Rural

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Cecil, Meek - (Still born)

3. (b) Social Security Number none

4. Sex M

5. Color or race W -

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) July 16 - 1940 -

8. AGE: Years Months Days If less than one day

- - - hrs. - min.

9. Birthplace R.F.D.I. Frostburg, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Adrian Meek

13. Birthplace Lonaconing Md

MOTHER 14. Maiden name Cecile R. Hart

15. Birthplace Frostburg, Md -

16. Informant Adrian Meek

Address R.F.D. No 1, Frostburg, Md

17. July 16 - 1940 (Burial, cremation, or removal) Date thereof July 16 1940 (month) (day) (year)

Cemetery or crematory Allegeny

Location Frostburg Md -

18. Funeral director Wm Adrian Meek

Address Hoffman, Md. R.F.D. Frostburg Md

19. July 16 1940 - Mrs. A.R. Walker

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1940, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at Birth July 16 1940 19

and that I last saw h alive on 19

Immediate cause of death Still Birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A M Eurle Jr MD

M. D. or other

Address Frostburg Md Date signed 7-16-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

07145

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days): 7 ds.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Route 3 Box 11 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Keyser, W. Va.
(Rural, give LOCATION)

Near McCoole Md

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Marvin Earl Miller

3. (b) Social Security Number:

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: ✓

B (b) Name of husband or wife:

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): June 23 1940

8. AGE: Years | Months 1 | Days 6 | If less than one day: hrs. min.

9. Birthplace: McCoole A. Co. R.F.D. 3 Box 11 Keyser W. Va. Md.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Laphy Miller
13. Birthplace: Flats W. Va.

MOTHER
14. Maiden name: Bessie M. High
15. Birthplace: Purgitsville W. Va.

16. Informant: Laphy E. Miller

Address: R-3-B-11 - Keyser West. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31 1940 (month) (day) (year)

Cemetery or crematory: Huffman Cemetery

Location: 8 Mi South Purgittville, W. Va.

18. Funeral director: D. S. Bond

Address: Barton, Md.

19. July 31 1940 (Date rec'd by registrar) A. J. Gaffenbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th 1940, at 3:15 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 1940, to July 30 1946, and that I last saw him alive on July 30 1940.

Immediate cause of death: Esophageal Stenosis — DURATION: 1 mo
Gastro-enteritis — 10 days
Due to: Bilateral Otitis media — 3 days
Dehydration & Malnutrition — 3 ds.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thorman Reeves M.D. M. D. or other

Address: Westernport Md. Date signed: 1-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07146

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 12 days

Stay in this community (yrs., or mos., or days) all her life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 402 Fayette
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Bessie Thomas McCullough Morgart

3. (b) Social Security Number 214-05-8299

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: Ralph C. Morgart

6(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Sept 10, 1883

8. AGE: Years 57 | Months 9 | Days 22 | If less than one day: hrs. min.

9. Birthplace: Cumberland Allegany, Md.
(Town, county, and state)

10. Usual occupation: Assistant Mgr-Bread Shop

11. Industry or business: Retail Bread Shop

FATHER
12. Name: John McCullough
13. Birthplace: Ireland

MOTHER
14. Maiden name: Annie McCullough
15. Birthplace: Ireland

16. Informant: Anna C. McCullough
Address 223 Wallace St-Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5, 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Md

18. Funeral director: Jacob Hafer

Address: Cumberland, Md.

19. July 5, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 2 1940, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30 1940, to July 2 1940

and that I last saw her alive on July 2 1940

Immediate cause of death: Cerebral

Due to: Hemorrhage — DURATION: 12 days

Due to

Other conditions

Major findings: (Include pregnancy within 3 months of death)

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Wm. T. Williams M. D. or other

Address: Cumberland Date signed 7/5/40

RECEIVED
AUG 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

071479

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Allegany Registration Dist. No.

Village or City Franklin Near No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Stillborn Baby Neff If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward. Swanton, Rte. 3, Garrett Co.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	white	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) July 9, 1940

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Franklin, Md.
(State or country)

FATHER

13. NAME Unknown.

14. BIRTHPLACE (city or town)
(State or country)

MOTHER

15. MAIDEN NAME Ola M. Smith

16. BIRTHPLACE (city or town) Stoyer, Md.
(State or country)

17. INFORMANT Mrs. Ola M. Neff
(Address) Swanton, Md Rt. 3.

18. BURIAL/~~CREMATION OR REMOVAL~~
Place Keys Cemetery Date July 11, 1940
Garrett Co. Md.

19. UNDERTAKER Herbert C. Leighton
(Address) Oakland, Md.

20. FILED July 11, 1940 Mrs. A. R. Haehn
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month), 9 (Day), 1940. (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw h alive on , 19 ; death is said to have occurred on the date stated above, at 11:30 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Stillborn	

Other **Contributory Causes** of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury

Nature of Injury

24. Wes diseese or injury in any wey releted to occupetion of deceased?

If so, specify

(Signed) R. C. Dulit, M. D. M. D.

(Address) Frostburg, Md. 7/9/40

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
AUG 2 1949
BUREAU OF V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

07148

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 13 Robert St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 13 Robert St (If rural, give LOCATION)

2.(a) If veteran, name war World War Veteran

3.(a) FULL NAME Charles Nester

3.(b) Social Security Number 705-07-6754

4. Sex male

5. Color or race white

6.(a) Single, married, widowed, or divorced married

6.(b) Name of ~~husband or~~ wife Amanda Troutman

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) July 22 - 1891

8. AGE: Years 49 Months 11 Days 20 If less than one day ..... hrs. ..... min.

9. Birthplace West, Va. (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business Balto & Ohio R R

FATHER 12. Name Geo. Nester

13. Birthplace West Va.

MOTHER 14. Maiden name Saville Garner

15. Birthplace West Va

16. Informant Amanda Nester

Address 13 Robert St

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 1940 (month) (day) (year)

Cemetery or crematory Fort Asbury

Location Frankford West Va.

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. July 15 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1940, at 3 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 1941, to July 12 1940 and that I last saw him alive on July 11 1940

Immediate cause of death Carcinoma of Rectum — DURATION 4 mth

Due to —

Due to —

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma

Date of op 7-11-39

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. J. Lanich M. D. or other

Address Cumberland Md Date signed 7-13-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 27 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

07149

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Allegany.

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Bon Secours, B & O Rail Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 n Cedar St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Ensley Nesbit (NISBET)

3.(b) Social Security Number 705-05-4783.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Catherine Bergman.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 6 1912

8. AGE: Years	Months	Days	If less than one day
27	10	4	hrs. min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Machinist Helper.

11. Industry or business: B & O Rail Road.

FATHER
12. Name: John Nesbit (NISBET)
13. Birthplace: Scotland

MOTHER
14. Maiden name: Rosalie Hartsock
15. Birthplace: Md

16. Informant: Mrs J.E. Nesbit
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13 1940 (month) (day) (year)
Cemetery or crematory: St Peter & Paul
Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland Md.

19. July 12 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10/40 19 at 10:10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/10/40 19 to 7/10/40 19 and that I last saw h alive on 7/10/40 19

Immediate cause of death: Coronary Occlusion

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M.D.
M. D. or other

Address 342 E. Main St. Date signed 7/11/40

CHANGE OF SPELLING OF SURNAME authorized by letter under DR. WILLIAMS, permanent filed, July 19, 1940.

CHANGE OF BIRTHDATE authorized by letter under DR. WILLIAMS
PERMANENT FILE July 26 1940/

WITHIN CORPORATE LIMITS.

07150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 212 Thomas St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 212 Thomas St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Walter E. Palmer

3. (b) Social Security Number: None

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widower

6.(b) Name ~~of husband~~ or wife: Ida Mae Hensel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: about 65 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: Elevator Operator

11. Industry or business: Court House

FATHER
12. Name: John Palmer
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Patrick
15. Birthplace: England

16. Informant: Elizabeth Hite

Address: City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Md

18. Funeral director: Louis Stein Inc

Address: Cumberland, Md

19. July 27 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940, to July 26 1940 and that I last saw h... alive on July 25 1940

Immediate cause of death: Chronic Interstitial Nephritis

Due to: Arteriosclerosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION: About 1938

Major findings of operations ..... Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Kj Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: no Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 133 Va Ave Date signed: 7/26/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

07151 Dr. Diehl

Reg. Dist. No. 9

WITHIN INCORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address (hospital, or institution): 34 Broadway

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 34 Broadway

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Vena A. Powell

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife: Athan Powell

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Nov 16 1877

8. AGE:

Years	Months	Days	If less than one day
63	7	26	hrs. min.

9. Birthplace: Edom, Va. (Town, county, and state)

10. Usual occupation: home wife home

11. Industry or business:

FATHER — 12. Name: Charles Masten

13. Birthplace: U.S.A.

MOTHER — 14. Maiden name: Mary Rinker

15. Birthplace: Va.

16. Informant: Athan Powell

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which): Date thereof: July 15-1940 (month) (day) (year)

Cemetery or crematory: allegany

Location: Frostburg

18. Funeral director: J. [illegible]

Address: Frostburg Md.

19. July 15 1940 (Date rec'd by registrar) mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1940 to July 12 1940, and that I last saw her alive on July 12 1940.

	DURATION
Immediate cause of death: Acute dilitation of heart	10 min
Due to: acute indigestion	7 hrs.
Due to: Diabetes mellitus	1 year.
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl, M. D. M. D. or other

Address: Frostburg, Md. Date signed 7/15/40

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24-a)

WITHIN CORPORATE LIMITS

9

CERTIFICATE OF DEATH

Reg. Dist. No. 07152

1. PLACE OF DEATH:

County: ~~Miners Hospital~~ Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 days

Stay in this community (yrs., or mos., or days): lifetime

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joseph H Pryor

3. (b) Social Security Number: 214-07-4492

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Florence Himmelwright Pryor

6(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): December 12, 1886

8. AGE: Years 53 | Months 6 | Days 22 | If less than one day ___ hrs. ___ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Janator

11. Industry or business: Celanese Corporation

FATHER
12. Name: John Pryor
13. Birthplace: Not known

MOTHER
14. Maiden name: Elizabeth Pryor
15. Birthplace: Md

16. Informant: Mrs. Florence Pryor
Address: Eckhart Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7 1940 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

16. Funeral director: Jacob Hafer
Address: Frostburg, Md.

19. July 6th 1940 (Date rec'd by registrar) Mrs. A. R. Walker, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1940, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1940, to July 4 1940, and that I last saw him alive on July 3 1940.

Immediate cause of death: acute septicemia
~~Streptococcic septicemia: 4 days.~~

Due to: neuritis left leg.

Due to: No accident, or injury. No focus of infection found. CWGR.

Other conditions: Blood culture showed a streptococcus, the cause of death.
(Include pregnancy within 3 months of death)

Major findings:
Of operations: none
Of autopsy

DURATION: 4 days
6-15-40

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ___ Date of ___
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 7/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (87-C)

CERTIFICATE OF DEATH

07153 Dr McLane
Reg. Dist. No. 9

1. PLACE OF DEATH:
County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 40 Washington
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 40 Washington
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joseph S. Richardson
3. (b) Social Security Number: None

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Clara Richardson
6(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): Sept. 17 — 1861
8. AGE: Years 78 Months 10 Days 2 If less than one day hrs. min.
9. Birthplace: Eckhart - alleg. Md. (Town, county, and state)
10. Usual occupation: retired
11. Industry or business
FATHER 12. Name: George Richardson
13. Birthplace: England
MOTHER 14. Maiden name: Alice Byrd
15. Birthplace: England
16. Informant: Mrs Clara Richardson
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21-1940 (month) (day) (year)
Cemetery or crematory: allegany
Location: Frostburg, Md
18. Funeral director: J J Durst
Address: Frostburg, Md
19. July 21 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1940, at 12:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to July 19 1940, and that I last saw him alive on July 18 1940.

Immediate cause of death	DURATION
Arteriosclerosis	? ?
~~Due to~~ Paralysis Agitans	8 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W O M Lane Jr MD M. D. or other
Address: Frostburg Md Date signed: 7-19-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

07154

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 526 Rose Hill Ave

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 6 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 526 Rose Hill Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Georgianna Schubert.

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Late Harry Schubert

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 20 - 1860

8. AGE: Years: 80 Months: 2 Days: 20 If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: At Home

11. Industry or business:

FATHER
12. Name: Elias Zimmerman
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Keiper
15. Birthplace: Md.

16. Informant: Mrs Eloise Compton

Address: Cumberland Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 12, 1940 (month) (day) (year)

Cemetery or crematory: Green Hill

Location: Martinsburg W Va.

18. Funeral director: V. L. Lempereur

Address: 202 Greene St. Cumbd Md.

19. July 11, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1940, at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1940, to July 10 1940, and that I last saw her alive on July 9 1940.

Immediate cause of death: Angina Pectoris — DURATION: sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos. W. Kroon M. D. or other

Address: Cumberland, Md. Date signed: July 10 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 8 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157-9

07155

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days in hospital

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town 531 PEARRE AVE Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME BABY PAUL EDWARD SHAFER

3. (b) Social Security Number None

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 24, 1940

8. AGE: Years | Months 1 mo | Days 6 da | If less than one day hrs. min.

9. Birthplace MD., Cumberland, Allegany (Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER: 12. Name ARTHUR SHAFER

13. Birthplace MARYLAND

MOTHER: 14. Maiden name VIRGINIA WELSH

15. Birthplace PENNSYLVANIA

16. Informant Arthur Shafer

Address 531 Pearre Ave, City

17. Removal (Burial, cremation, or removal. Which?) Date thereof Jul 31 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Hagerstown Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. July 31, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 30 1940, at 1:20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1940, to July 30 1940 and that I last saw him alive on July 30 1940

Immediate cause of death Post Operation Shock

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Congenital Pylorus Stenosis

Date of op. July 29 40

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. E. Ospeld M. D. or other

Address Cumberland Date signed July 30-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07156

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or instn. (yrs., or mos., or days) 1 day
Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Roberts Place, Bowling Green
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Gyneth Ann Shankoltz

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Baby

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 10, 1940

8. AGE: Years | Months | Days: 1 | If less than one day: ____ hrs. ____ min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name William Harrison Shankoltz
13. Birthplace Meyersdale, Penna.

MOTHER
14. Maiden name Dora Murphy
15. Birthplace Grantsville, Md.

16. Informant William H. Shankoltz
Address Roberts Place - Route #5

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1940. (month) (day) (year)

Cemetery or crematory Mt. Zion
Location National Hwy W. of Frostburg

18. Funeral director Jacob Hofer
Address Cumberland Maryland

19. July 12, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1940, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10, 1940 to July 11, 1940, and that I last saw her alive on July 11, 1940.

Immediate cause of death	DURATION
Prematurity (2 wks gestation)	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other
Address 40 N. Gilpin St. Date signed 7-11-40

RECEIVED
AUG 6 1940
BUREAU V. S.

07157

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Girl Shillingburg

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 15, 1940

8. AGE: Years | Months | Days | If less than one day: 1½ hrs. ... min.

9. Birthplace: Westernport, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Joseph Herome Shillingburg
13. Birthplace: Beryl, W. Va.

MOTHER
14. Maiden name: Mary Angela Dichera
15. Birthplace: Piedmont, W. Va.

16. Informant: Mary Angela Dichera
Address: Piedmont, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 16, 1940 (month) (day) (year)

Cemetery or crematory: St. Peter's

Location: Westernport, Md.

18. Funeral director: Joseph Shillingburg
Address: Westernport, Md.

19. July 16 1940 (Date rec'd by registrar) A. Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15, 1940, at 4:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 15, 1940, to July 15, 1940 and that I last saw her alive on July 15, 1940

Immediate cause of death	DURATION
Prematurity 7 mo	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Thomas Reeves, M.D.
M. D. or other

Address: Westernport, Md. Date signed: 7/16/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

07158

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 22 days

Stay in this community (yrs., or mos., or days): 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Oakland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: East Oak St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Shipley, Thoburn Le Noir

3. (b) Social Security Number: 218-10-3915

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilma "DeWitt" Shipley

6(c) If alive, give age: 31 years

7. Birth date of deceased (mo., day, yr.): June 6, 1893

8. AGE: Years: 47 Months: – Days: 29 If less than one day: hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Painter & Glazer

11. Industry or business: General

FATHER
12. Name: Hyer L. Shipley
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Mary C. Schmelling
15. Birthplace: Baltimore Md

16. Informant: Clyde H. Shipley
Address: Mt. Lake Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7, 1940 (month) (day) (year)

Cemetery or crematory: Oakland

Location: Oakland, Maryland

18. Funeral director: Herbert C. Leighton
Address: Oakland, Md

19. July 7, 1940 (Date rec'd by registrar) J. P. Frankling M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1940, at 3 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/14/40 19 , to 7/5/40 19 , and that I last saw h alive on 19

Immediate cause of death: Peritonitis due to ruptured gastric ulcer

Due to: cerebrovascular collapse

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John K. Rozum M.D.
M. D. or other

Address: Cumberland Md Date signed: 7/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 30 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-B)

CERTIFICATE OF DEATH

07159

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occurred: 416 Grand Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 416 Grand Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nellie Viola Smith

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James L. Smith
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Aug 6 1879

8. AGE: Years	Months	Days	If less than one day
60	10	28	....hrs. ....min.

9. Birthplace: Chambersburg Pa
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at Home.

FATHER
12. Name: Benjamin Yarger
13. Birthplace: Chambersburg Pa

MOTHER
14. Maiden name: Barbara A Cramer
15. Birthplace: Chambersburg Pa.

16. Informant: James L Smith
Address: Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof July 6 1940
(month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland Md

18. Funeral director: Louis Steinmetz Inc.
Address: Cumberland

19. July 6 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4 1940 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1940 to July 4 1940
and that I last saw h.e.r. alive on July 1 1940

Immediate cause of death	DURATION
Carcinoma (Probably adeno)	
Due to: Ca Corpus Uteri	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arthur T. Jones M.D.
M. D. or other
Address: 40 N. Liberty St. Date signed 7-8-40

RECEIVED
AUG 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07160

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days): 9 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: 429 HOMER STREET, Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: MR. JOHN E. SQUIRES

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: CAROLYN KIFFNER
6(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 28, ~~1869~~ 1869

8. AGE: Years: 70 ~~80~~ | Months: 7 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: WEST VIRGINIA (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business: from the B & O - R.R.

12. FATHER Name: JAMES SQUIRES
13. Birthplace: (DECEASED) West Virginia

14. MOTHER Maiden name: MARY ANN GULL
15. Birthplace: (DECEASED) West Virginia

16. Informant: Mrs. Carolyn Squires -
Address: 429 Homer St.

17. Burial - (Burial, cremation, or removal. Which?) Date thereof July 18 1940 (month) (day) (year)
Cemetery or crematory: Greenmount Cemetery
Location: Cumberland, Md

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md

19. July 16 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 11:50 AM

20. DATE OF DEATH: JULY 15 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-6- 1940, to 7-15- 1940, and that I last saw h[illegible] alive on 7-15-40 1940

Immediate cause of death	DURATION
Myocardial degeneration	3
arteriosclerosis	7
Due to	
Due to	
Other conditions Benign hypertrophy Prostate	about 7 yrs.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: Howard L. Folson, M.D. M. D. or other
Address: Cumberland, Md. Date signed 7-15-40

RECEIVED
JUL 30 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

07161

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 T

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 S. Waverly Terrace (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Mary M. Stafford

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William E. Stafford
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 2 1847

8. AGE: Years 92 | Months 7 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: House duty
11. Industry or business: Own House

FATHER
12. Name: Joshua Shahan
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Elizabeth Trickett
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29/40 (month) (day) (year)
Cemetery or crematory: Queens Rohut Cemetery
Location: Keyser W Va

18. Funeral director: William H. Knight
Address: Cumberland Md.

19. July 29 1940 J.P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1940 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31 1940 to July 27 1940
and that I last saw h[illegible] alive on July 27 1940

Immediate cause of death: Fract Intertrochanteric Left [illegible] — DURATION: 24 hrs.
Due to: Cast applied to Lt. leg for fractured femur.
Due to: Age & June 3, 1940
Other conditions: Tripped on rug, and fell, fracturing his right leg. Dying of heat prostration July 27, 1940. Cerebral.
(Include pregnancy within 3 months of death)

Major findings of operation: None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of June 3rd, 1940.
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) in his home
Means of injury accidental fall. Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other
Address: Cumberland Date signed 7-29-40.

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

07162

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 171 N Mechanic St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 171 N Mechanic St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Stein

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Wm. Henry Stein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29 1872

8. AGE: Years	Months	Days	If less than one day
68		29	..... hrs. ..... min.

9. Birthplace: Cumberland Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Wilford Smith
13. Birthplace: Germany

MOTHER
14. Maiden name: Catharine Weisenmiller
15. Birthplace: Germany

16. Informant: Mrs Geo - Mc Snider

Address: 338 Bedford St

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1940 (month) (day) (year)

Cemetery or crematory: Grasmere Beneficial

Location: Cumberland, Md

18. Funeral director: Louis Stein Sons

Address: Cumberland Md

19. July 18 1940 (Date rec'd by registrar) J. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.er alive on 7/17/40 19.....

Immediate cause of death	DURATION
Acute Nephritis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Lee K. Rozzell M.D.

Address: Cumberland Md M. D. or other

Date signed: 7/18/40

RECEIVED
AUG 6 1940
BUREAU V. S.

07163

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: James Thomas Stottlemyer

3.(b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Bertha "Grant" Stottlemyer

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): March 17, 1866

8. AGE: Years: 74 Months: 3 Days: 0 If less than one day: ..... hrs. ..... min.

9. Birthplace: Hancock, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Tunnel Construction

FATHER
12. Name: Jackson Stottlemyer
13. Birthplace: Hancock, Maryland

MOTHER
14. Maiden name: Mary Haywood
15. Birthplace: Hancock, Maryland

16. Informant: William Stottlemyer

Address: Cresaptown, Md.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: July 19, 1940
(month) (day) (year)

Cemetery or crematory: Lease Cemetery

Location: Cresaptown, Maryland

18. Funeral director: Jacob Hafer

Address: Cumberland, Maryland

19. 7/19, 1940
(Date rec'd by registrar)

M. G. Fremont
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17, 1940 at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 1940, to July 17 1940 and that I last saw him alive on July 10 1940

Immediate cause of death: Uremia, Coma, Chronic Nephritis

	DURATION
	1 week
	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. A. Koon
M. D. or other

Address: Cumberland Md. Date signed: July 18-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M)

(T)

RECEIVED
AUG 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

07164

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: ALLEGANY HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County ALLEGANY

City or town CRESAPTOWN Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME BABY GIRL STOUFFER

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 21, 1940 10.36 a.m.

8. AGE:

Years	Months	Days	If less than one day
0	0	0	8 hrs. 0 min.

9. Birthplace CUMBERLAND, MD
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name RAYMOND E. STOUFFER
13. Birthplace Md

MOTHER
14. Maiden name Mary Eliz Witte
15. Birthplace Md

16. Informant Raymond Stouffer
Address Cresaptown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1940 (month) (day) (year)

Cemetery or crematory MADLEY

Location MADLEY, PA

18. Funeral director Harvey Ziegler
Address Hyndman, Pa.

19. July 22 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1940, at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1940, to July 21 1940, and that I last saw h alive on July 21 1940.

Immediate cause of death Premature Infant 6 1/2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Allen G. Wernsford M. D. or other

Address 41 Green St Cumberland Date signed July 22 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07165

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 8 days

Stay in this community (yrs., or mos., or days): 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Morgan

City or town: Paw Paw Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Mrs. Clara Sunderlin

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eli Sunderlin

6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): December 1, 1872

8. AGE: Years 67 Months 7 Days 24 If less than one day ___ hrs. ___ min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Robert Young
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margaret Thomas
15. Birthplace: Pennsylvania

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 28, 1940 (month) (day) (year)

Cemetery or crematory: Parks of Capapon Cemetery

Location: Hampshire Co. W.Va.

18. Funeral director: Jacob Hofer
Address: 230 Baltimore Ave.

19. July 26 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1940, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 1940, to July 25, 1940, and that I last saw her alive on July 25, 1940.

Immediate cause of death: Pat Carcinoma Stomach - Many Metastases practically Obstructing Pylorus

Due to: Perforation & Fistula

Due to: Navel

Other conditions: (Include pregnancy within 3 months of death)

Major findings:

Of operations: Above

Of autopsy: None

DURATION: 18 months

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? ___ (City or town) ___ (County) ___ (State)

Injured at home, farm, industry, public place (where?) ___

Means of injury ___ Injured at work?

23. SIGNATURE: A H Hawkins M. D. or other

Address: Cumbd Md Date signed ___

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

07166

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(S)

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 8 W. Oldtown Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: TAYLOR, BABY GIRL (STILLBORN)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 18, 1940

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Miss Rosie Taylor

15. Birthplace: Maryland, Sperry Gap

16. Informant: Memorial Hosp. Address: Cumberland Md.

17. (Burial, cremation, or removal. Which?) Cremation Date thereof July 18, 1940 (month) (day) (year)

Cemetery or crematory: Destroyed

Location: at

18. Funeral director: Memorial Hosp. Address:

19. July 24 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1940, at 10p m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from July 14 1940 to July 18 1940, and that I last saw her alive on July 18 1940

Immediate cause of death	DURATION
Intrauterine Asphyxia	7-18-40
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other

Address: 40 N. Liberty St. Date signed: 7-23-40

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

07167

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(S)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME BABY BOY THOMAS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11, 1940

8. AGE: Years | Months | Days | If less than one day Stillborn hrs. min.

9. Birthplace Cumberland Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Thomas

13. Birthplace Vanbush, W. Va.

MOTHER 14. Maiden name Evelyn Metz

15. Birthplace Greentoville, Md.

16. Informant Memorial Hosp.

Address Cumberland Md.

17. Cremated (Burial, cremation, or removal. Which?) Date thereof July 11, 1940 (month) (day) (year)

Cemetery or crematory Foetus destroyed in hospital

Location

18. Funeral director

Address

19. July 15, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Stillborn July 11 1940, at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1940, to July 11 1940 and that I last saw him alive on Stillborn 19

Immediate cause of death	DURATION
Intrauterine Asphyxia	7-11-40
Due to Maternal Pre eclampsia	3 wks +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 40 N. Liberty St. Date signed 7-13-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

STATE OF MARYLAND—CERTIFICATE OF DEATH

07168

(91-B)

1. PLACE OF DEATH

County Allegany Registration Dist. No. 4

Village or City Cumberland No. 941 Md Ave. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Harley Morgan Thompson If U. S. Veteran, specify WAR none

(a) Residence: No. 941 Maryland Ave St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a. If married, widowed, or divorced HUSBAND ~~of~~ ~~(or)~~ WIFE ~~of~~ Mary E. Hammer

6. DATE OF BIRTH (month, day, and year) Sept 1 - 1895

7. AGE Years 44 Months 9 Days 23 If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Social Security 214-07-5135 Spinner.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Silk Mill.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) W. Va.

FATHER

13. NAME Geo Thompson

14. BIRTHPLACE (city or town) (State or country) W. Va.

MOTHER

15. MAIDEN NAME Mary E Hines

16. BIRTHPLACE (city or town) (State or country) W. Va.

17. INFORMANT (Address) Wife - Mrs. Mary Thompson 941 Maryland Ave.

18. BURIAL, CREMATION, OR REMOVAL Place Zion Lutheran Cem Date July 27, 1940

19. UNDERTAKER (Address) V. L. Lempereur

20. FILED July 27, 1940 J. P. Franklin, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 24 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 24, 1940, to July 24, 1940 I last saw him alive on July 24, 1940; death is said to have occurred on the date stated above, at 8:00 P.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Acute Endo-Carditis:	2/1/40
Duration: one day. cwza	

Other **Contributory Causes** of Importance: none.

Name of operation ___ Date of ___

What test confirmed diagnosis? Clinical Was there an autopsy? no.

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ___

(Signed) L. J. Lanich M. D.

(Address) Cumberland Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

(T)

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

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AUG 8 1940
BUREAU V. S.

214-67-5705

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

Dr. Kilday

071699

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mt Savage Rd.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Richard Uhl

3. (b) Social Security Number: 214-01-0104

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Divorced

B (b) Name of husband or wife: Dale Sweely Uhl

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 29-1885

8. AGE: Years 54 | Months 9 | Days 0 | If less than one day ____ hrs. ____ min.

9. Birthplace: Mt. Savage, Allegany County, Maryland
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Union Mining Co.

FATHER
12. Name: Chas. R. Uhl
13. Birthplace: Wellersburg, Pa.

MOTHER
14. Maiden name: Alice Holtzman
15. Birthplace: Mt. Savage, Md.

16. Informant: Mrs Chas Burch
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 1, 1940 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt. Savage, Md.

18. Funeral director: J. J. Daurst
Address: Frostburg, Md.

19. Aug 1st 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/29/40 19__, at 10 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/29/40 19__, to 7/29/40 19__, and that I last saw h IM DEAD alive on 7/29/40 19__.

Immediate cause of death: CHRONIC MYOCARDITIS PULMONARY EDEMA.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: NONE
Of autopsy: NO

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: John Kilday M.D.
M. D. or other

Address: Frostburg, Md. Date signed: 7/31/40

RECEIVED
AUG 2 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

07170

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Potomac River, 25 Miles South of Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 200 Decatur St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Francis Martin Weber.

3.(b) Social Security Number 220-10-2643

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Louise Quantz

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6. 1883

8. AGE: Years 57 | Months 3 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland, Md
(Town, county, and state)

10. Usual occupation: ~~Concrete~~ Poured Concrete

11. Industry or business: Savage River Dam

FATHER
12. Name: Geo Weber.
13. Birthplace: U.S.A.

MOTHER
14. Maiden name: Caroline Smith
15. Birthplace: U.S.A.

16. Informant: Mrs F M Weber.
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 40 (month) (day) (year)

Cemetery or crematory: Trinity Lutheran

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. July 30 1940 (Date rec'd by registrar) Mrs P.A. Shanahan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th., 1940 about 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Accidental drowning.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7/28/40

Where did injury occur? Potomac River, east of Cumberland (City or town), Allegany (County), Maryland (State)

Injured at home, farm, industry, public place (where?) Potomac River

Means of injury: drowning Injured at work? no

23. SIGNATURE: Lucius H. Carson, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed 7/29/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07171

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 225 Baltimore Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 225 Baltimore Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Edward H White

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie Kaufman

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1870

8. AGE: Years 70 | Months 1 | Days 6 | If less than one day hrs. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Doctor

11. Industry or business Own Practice

FATHER 12. Name Charles White

13. Birthplace Germany

MOTHER 14. Maiden name Rachael Goldsmith

15. Birthplace Germany

16. Informant Mrs Carrie White

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jul 16 1940 (month) (day) (year)

Cemetery or crematory Baltimore Hebrew Cong. Cem

Location Baltimore, Md

18. Funeral director Louis Stein Sons

Address Cumberland Md

19. July 15 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1940, to July 13 1940 and that I last saw him alive on July 13 1940

Immediate cause of death Coronary Thrombosis

Heart Attack. DURATION 4 days.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. I. Williams M. D. or other

Address Cumberland Date signed 7-15-40

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AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

07172

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 1008 Gleenwood St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Gleenwood St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Henry Whitman

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Effie L Wilkinson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 20 1872

8. AGE: Years 67 Months 8 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.

(Town, county, and state)

10. Usual occupation: Dental Work.

11. Industry or business: Own Laboratory

FATHER 12. Name: Henry Whitman

13. Birthplace: Germany.

MOTHER 14. Maiden name: Elizabeth Huff.

15. Birthplace: Germany

16. Informant: Mrs Elizabeth Whitman

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14, 40 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19. July 12, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1940, at 6 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to July 11 1940 and that I last saw him alive on July 10 1940

Immediate cause of death: Carcinoma of Sigmoid — DURATION 1½ yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma Obstructing Sigmoid Date of op July 1939

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. W. Chason M.D. M. D. or other

Address: 126 Elmwood Cumberland Md Date signed 7/11/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124 C)

07173

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 71 DAYS

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 123 SPRUCE STREET (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. CORA WILKINSON

3. (b) Social Security Number None

4. Sex FEMALE

5. Color or race WHITE

6. (a) Single, married, widowed, or divorced WIDOWED

6 (b) Name of husband or wife GUY WILKINSON

DECEASED 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1888

8. AGE: Years 51 Months 10 Days If less than one day hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

FATHER 12. Name JOHN B. PITZER

13. Birthplace MARYLAND

MOTHER 14. Maiden name JANE BYROAD

15. Birthplace MARYLAND

16. Informant Ralph E Wilkinson

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 23 40 (month) (day) (year)

Cemetery or crematory Hillcrest Cem

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. July 22 1940 J. P. Franklin, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 20 1940 12:25 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/16/40 19 to 7/20/40 19 and that I last saw her alive on 7/20/40 19

Immediate cause of death Myocarditis (chronic) Cirrhosis Liver

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Richard J. Williams M.D. M. D. or other

Address 34 Va. Ave Date signed 7/22/40

DR. R. WILLIAMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 8 1940
BUREAU V. S.